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BULLETIN of the MENNINGER CLINIC

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Contents:

The Individual's Responsibility for World Peace. *By* G. Brock Chisholm, M.D. 73

A Suggested Basic Psychiatric Reading List. *By* Karl Menninger, M.D. 81

Dynamic Aspects of Teaching Psychology. *By* Rudolf Ekstein, Ph.D. 90

Diagnosis and Treatment of Schizophrenia. *By* Karl Menninger, M.D. 96

Book Notices 107

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BULLETIN of the
MENNINGER CLINIC

VOLUME 12 MAY, 1948 NUMBER 3

THE INDIVIDUAL'S RESPONSIBILITY FOR WORLD PEACE

By G. BROCK CHISHOLM, M.D.

The following address was given by Dr. Chisholm at the sixth annual meeting of The Menninger Foundation in Topeka, October 6, 1947. At this meeting the Board of Trustees unanimously elected Dr. Chisholm an honorary member of the Foundation. The membership was tendered Dr. Chisholm by Dr. C. F. Menninger, chairman of the Board of Trustees, with this citation:

CITATION FOR DR. G. BROCK CHISOLM

Executive Secretary of the Interim Commission of the World Health Organization, Geneva, Switzerland

In recognition of his unique contributions to human welfare;

As a thinker and leader, a man of wide horizons and broad sympathies, a psychiatrist, a physician, a statesman, a Canadian, but also a citizen of the world;

As the first dynamically oriented psychiatrist in Canadian medicine;

As a pioneer, in the medical service of a large national Army, in the development of methods for matching a man's capacity to his job assignment;

As Director General of medical services of the Canadian Army;

As a leader in bringing awareness to his people of the continuing needs for which their returning veterans require the generous services of the community;

As a world citizen and public health administrator, with understanding of people and far-sighted vision of their universal needs, inspiring and guiding the organization and functioning of the World Health Organization;

The Board of Trustees of The Menninger Foundation do hereby and with honor welcome G. Brock Chisholm to the Fellowship of the Foundation as an Honorary Member.

These are times when things have come adrift and the ancient securities on which many of us stood for a long time have loosened and are no longer safe. We have thought ourselves safe for a great variety of reasons. Most of those reasons have lost, at least to some degree, their validity. We are now living in a new kind of world ushered in by the explosion of the atomic bomb and now, still more potentially horrible, a world which holds the ghastly possibility of biological warfare. I don't know whether many of us appreciate that already the atomic bomb is relatively obsolete. Its terrors

represent, relatively speaking, child's play compared to what can be done by biological methods of waging war.

Our conditions of survival have changed drastically in the last three or four years. Many of us do not yet appreciate that fact. We are still feeling and thinking in the terms in which we were brought up as children, in an entirely different kind of world from that in which we live now and in which our children are growing up.

It is not long ago since people could hate each other quite extensively; since whole groups of people could find it impossible to live in peace with each other; since people could fight each other over considerable areas, yet their conflicts meant almost nothing to the rest of the world. Now every conflict, every aggression, every difference of opinion, every potential threat from politicians talking for local consumption, from opinionated commentators on the radio, or from columnists saying things for local political effect or for enhancing their own prestige, are taken seriously by people on the other side of the world. These may be quoted and requoted, sometimes distorted. Much damage may be done even by this careless talking and careless writing which until quite recently was utterly unimportant.

We must accept the fact that there are in the world now, as there always have been, a great variety of experiments in living, none of which, including our experiment, has yet proven itself to be the final right and best method. There are things wrong even with our way of life as there are things wrong with every way of life of which we know anything yet. It does not behoove us to believe that our particular way, in whatever part of the world we live, should be imposed on anybody, at this stage of our experiment.

It is necessary that we should learn to see things from other people's point of view. Our points of view are specific for us because of the way we were brought up, the original premises that surrounded us when we were children. But these are not the same original premises, they are not the conditions of life, under which millions of people were brought up in other parts of the world. Their backgrounds and reactions are different, and our problem is to reach methods of communications between entirely different kinds of civilization. That is quite a problem, but it is essential that we should do something about it.

We must face the fact, and it is a very serious fact indeed, that all through recorded history, and all through implied history before that, people have been fighting each other enthusiastically and almost continuously. Mass fighting has been one of the more consistent major patterns of behavior throughout the history of the human race. People have been living competitively by killing each other off from time to time. Major wars throughout recorded history have occurred perhaps every fifteen or twenty years.

We are faced with the perfectly ghastly fact, very suddenly, that warfare,

competitive survival, has now become utterly obsolete as a method of staying alive. It can no longer work because it has become too efficient. It is perfectly possible now to destroy all life over enormous areas of the earth by using biological weapons. It can be done with methods that are available now. The implications of that statement are terrible. It means, and it means literally, that as far as survival warfare is concerned, all the weapons we have used and thought of in the past have become obsolete—all these things are utterly irrelevant to a future war.

Biological warfare has promoted any little country, no matter how small, to a country which can compete successfully with any other country in the world by using biological weapons. Heavy industry is no longer necessary. Manufacturing ability means nothing. Man-power means nothing. All that is necessary is one bacteriologist and a few enthusiastic fanatics who will spread the results of the labor of the bacteriologist wherever they want to spread them.

Therefore, the problem becomes perfectly clear. It is necessary for man to learn to live at peace with man or he will not survive at all. This is a new concept. Man has never lived at peace with man except in isolated areas and for very short times; from now on he must live at peace with man or else die out as a species. Therefore, we must begin to look at ourselves and wonder what is wrong with us, because we are the people, as were our parents and our grandparents and great-grandparents, who fight each other every fifteen or twenty years and always have done so.

Many people are seriously disturbed at the conflicts which are now found all over the world between nations—conflicts around conference tables, which are mirrored in newspapers, and on the radio. But I think we shouldn't take these things too seriously. Actually these are, as all psychiatrists will recognize, excretory. These are ways of using up aggressive pressures. We feel much better if our representative at a United Nations table gives somebody else hell. We say that will show them that we're tough. Then we feel much more friendly afterward. That is a well known phenomenon.

I think we shouldn't worry too much about the conflicts that show in the organs of the United Nations. The fact is that an astounding number of agreements have been reached between an astounding number of nations over the last three years or so. We had some amusing illustrations of the relative importance of agreement and disagreement at the International Health Conference last summer when some sixty-four nations met to consider the Constitution of a World Health Organization. Sixty-one nations signed the Constitution of the World Health Organization after only four weeks of discussion. Since then three other nations have signed. Never before in history have sixty-four nations signed anything except the Postal

Union and that didn't tie them down very much. But sixty-four nations actually did sign a most drastic document which gave extensive powers to a new untried World Health Organization. The newspaper men generally were very disappointed about it. Some of them sat at meeting after meeting and found nothing worth reporting at all. They said, "What kind of a meeting is this, nobody fights anybody else?" I suggested that they must recognize some drama in agreement. "There is no news in agreements", they said and didn't report it. Actually the drama of agreement by sixty-four nations to sign the things they signed is a most astonishing phenomenon and should be noted by all peoples in the world.

The difficulty is that while a dozen amazing agreements will be reached there may be one disagreement which doesn't find its solution immediately and that is what makes all the headlines. The Russians have to show only the slightest sign of disagreement about anything at all and there are headlines all over the world about it. The Americans have only to do the same thing, as far as Europe is concerned, and there are headlines about it. Actually the Americans quite frequently agree, and the Russians quite frequently agree with other nations, too. Only nobody mentions it when they do. It was hardly known for instance that the Russians had three delegations at the World Health Conference last summer in New York, that the Russian delegations took an active and cooperative part in the whole work of that conference, as did all the other nations, and that they signed along with everybody else at the end of it.

It is worth noting that sixty-four nations have recognized some of the necessities for which the world must have answers in the reasonably near future. In the Constitution of the World Health Organization are some of the indications of that recognition. It begins:

"The States parties to this Constitution declare, in conformity with the charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and securities of all peoples." And the first statement is a definition of health: "Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

"The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions."

"The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states."

"The achievement of any state in the promotion and protection of health is of value to all."

"Unequal development in different countries in the promotion of health

and control of disease, especially communicable disease, is a common danger."

"The healthy development of the child is of basic importance." And here follows a most important statement: "The ability to live harmoniously in a changing total environment is essential to such development." This is recognition by sixty-four nations that the next generation, to be able to survive at all must be changed drastically from what their parents have been because this generation is not capable of living harmoniously in a changing total environment.

"The extension to all peoples of the benefit of medical, psychological, and related knowledge is essential to the fullest attainment of health." "Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people." "The governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures." "Accepting these principles and for the purpose of cooperation among themselves and with others to promote and protect the health of all peoples, the contracting parties agreeing to the present Constitution hereby establish the World Health Organization as a specialized agency with the terms of Article 57 of the charter of the United Nations."

The objective of the World Health Organization is stated very simply, "The objective shall be the attainment by all peoples of the highest possible level of health." And health, I would remind you, is defined as "a state of complete physical, mental and social well being, not merely the absence of disease or infirmity."

It is not too discouraging when sixty-four nations can meet and in four weeks agree to all these principles and agree to the methods by which something should be done about these principles.

It is true that since that time not all of them, only a small proportion of them, have ratified their signatures to the Constitution. In the meantime these nations signed an arrangement setting up an Interim Commission. They elected eighteen nations, each of which sent a representative, not a representative of that nation—a representative *from* that nation to represent the interests of all sixty-four nations, to work as an interim commission to carry on in the meantime the necessary work in this world health field; these were the carrying on of obligations assumed previously by the League, by the Office International d'Hygiene Publique in Paris, by UNNRA and other organizations, statutory obligations controlling the spread of disease across national boundaries and a great many other obligations.

As soon as twenty-six of the United Nations have ratified their signatures to the Constitution, or as soon after that as possible, the first World Health Assembly is to be called together and they will set up the World Health

Organization. At the present time fifteen of the United Nations have ratified their signatures and six other nations which are not members of the United Nations have also ratified. The United States is not among those which have ratified. It is expected that a sufficient number of nations will have ratified before the end of this year so the first World Health Assembly will be called together sometime about March or April of 1948, at which time the World Health Organization will come into full being.

The responsibilities of the Interim Commission itself are rather extensive. There are offices in New York and in Geneva, Switzerland. It has as employees about thirty people in New York and about ninety in Geneva.

It does its work typically through expert committees, committees selected from experts in various fields of health from any country in the world. Committees are now functioning in a variety of fields. Such fields are, for instance, the unification of pharmacopeias throughout the world, a very important thing because there have been many drugs discovered during the war and these do not appear in the pharmacopeias of very many nations and there is no complete world wide pharmacopeia available. Another is the biological standardization committee. Its duty is to establish standards so when any country buys penicillin, streptomycin or other biologicals from any other country they will know what they are getting in terms of purity and potency.

An expert committee is working in the field of international control of infectious diseases. Another committee is concerned with the epidemic control of the Mecca pilgrimage, which has always been a very difficult problem. Another committee is working on yellow fever which over a large part of the world is a great threat. Others work on tuberculosis, venereal disease, revision of quarantine conventions, revision of the lists of causes of disease and death and so on. A wide variety of activities are being carried on also by the Interim Commission preparatory to setting up the World Health Organization.

The Interim Commission is not going into the mental health field because though there are many responsibilities laid out in the Constitution of the World Health Organization it was felt that the terms of reference of the Interim Commission and the money available to it would not allow it to go into this particular field. However, certain things are happening in relation to mental health. The Interim Commission, while itself not doing anything specifically and directly about mental health, has members who are doing what they can individually to stimulate work in this field on the part of many other people.

Actually every committee of the United Nations, every committee of every specialized agency of the United Nations, and every meeting of every subcommittee, is a move in the direction of mental health and world citizen-

ship. Every one of these meetings represents lines drawn across international boundaries. They represent large numbers of people coming to know each other, visiting each other in their own countries, living in each others' houses, getting to know each others' families, struggling with each others' languages and gradually becoming more than ever before in the history of the world one people.

There is a big lesson in this. All over the world now national representation has become important, as international relationships mean more than ever before. We are electing people who are going to represent us in relation to the rest of the world. I wonder if we have ever taken this problem seriously enough. I wonder if we are satisfied with the people who represent us in our relations with all the other people in the world.

It is an extremely difficult assignment. One must study history and sociology, one must know something of psychology and religions if one is going to work with other kinds of people. I think we must in all our countries demand with a very sure, strong voice that the people who represent us in our foreign relationship, the people who are going to keep us alive or get us all killed, should know their job. Knowing their jobs involves knowing all the kinds of people with whom they work and with whom they negotiate. It involves knowing their history, how they think and how they feel and what their reactions to every kind of suggestion will be. Only so can we possibly hope that our representatives will be able to ensure that we live in peace with the other people in the world.

Let us stop fooling ourselves. Our problem is no longer just to live at peace with a few great powers. Our problem now is to live at peace with everybody, which no country in history has ever succeeded in doing. And yet if we would survive at all that is what we must do and we must do it from now on.

Therefore, our responsibility becomes very great. The responsibility of those people who represent us in our foreign relations becomes colossal; and the responsibility of every citizen who votes for those people is very serious indeed.

There is a further great responsibility which we must meet. This responsibility is recognized by sixty-four nations in the Charter of the World Health Organization: the responsibility to bring up children capable of living in ways in which we have not been capable of living, children capable of facing honestly realities that have frightened us so much that we have turned and looked the other way and pretended they weren't there. This has been our old familiar pattern.

A child is entitled to be told the truth by its parents and if the parents don't know what the truth is the child is entitled to be told that too. And if the parents think one thing but they know thousands or millions of people

in the world think something else, a child is also entitled to be told that; and not to be told because his parents happen to think something that this is utter, final, universal truth accepted all over the world. Because it isn't and it isn't sound to tell the child it is. If you do then his kind of people are to him right, and all the other kinds of people, the people on other sides of the world who are different, are all wrong and bad.

These are our problems. Our own honesty is first; our own ability to face facts, to discount our own emotional reactions, to recognize we are not the repository of all truth and all certainty and that other people have some little claim to attention as well. And then to bring up a new kind of child who is able to use his brain to think with, no matter how painful that may be and will be the kind of person who will do something about it when he reaches conclusions, who will take steps, no matter how drastic, no matter how revolutionary, no matter how painful, to do things that need to be done. These are the things that we have not been able to do. Our responsibility is to help the next generation to be other than we have been.

You people here in Topeka have this responsibility as everyone else has. You have the great advantage of having, as I suggested to you before, a center of high social consciousness here in Topeka. You are signally favored in having that center here. I hope you use it. I hope that it will be possible for all of us to do enough, soon enough, so that our children may survive.

A SUGGESTED BASIC PSYCHIATRIC READING LIST, 1948

The preparation of the following list of books dealing with various aspects of psychiatry came about in the following way. For the revised edition (1945) of *The Human Mind*, lists of the generally accepted and recommended readings relating to various phases of psychiatry were assembled. A very considerable amount of time was put into this, not only by the author, but by a number of colleagues over the country with whom he consulted. The selections, while far from complete, represent in approximately 500 titles the books chiefly used by American psychiatrists.

One difficulty with so long a list, however, is the fact that the beginner in psychiatry is not quite sure which of the books he should read first, and is apt to be appalled by the length of the list. Accordingly it was suggested that it would be useful to select the books most suitable for first year residents, those most suitable for second year residents, those most suitable for advanced students, and those most suitable for general practitioners who wish to gain some idea about psychiatry.

This proved to be a formidable undertaking and one requiring more experience in the teaching of graduate psychiatry than any of us now possesses. The general philosophy and also the practice of psychiatry is so new that it would be very difficult to get a large concurrence for any truly representative lists of this type.

When, therefore, in the spring of 1947 Dr. Kenneth Appel of Philadelphia, Chairman of the Committee on Hospitals of the Group for the Advancement of Psychiatry, requested that the writer draw up a tentative list of thirty books which might be considered basic readings in psychiatry, the task seemed relatively simple and was essayed with what proved to be an unjustified temerity.

After very careful examination of many lists, in which I was greatly assisted by Dr. George Devereux, associate professor of anthropology in the Institute of Psychological Medicine (Menninger Foundation) and the librarians, Miss Ann Perry of the Winter Veterans Administration Hospital and Miss Vesta Walker of the Menninger Foundation, a list of titles was submitted to those members of the Group for the Advancement of Psychiatry who were present at the meeting in Minneapolis in July, 1947. Numerous additions and deletions were made, and the list reformulated, submitted to quite a number of additional colleagues and revised to what might be called an antepenultimate stage as of January 1, 1948.

It is to be emphasized that any such list as this should be *dated*, since additional books will certainly come to be recognized as definitive or standard year after year as our science grows and develops. Some of those now

listed will cease to have their present importance. Titles have certainly been omitted which should have been included, and perhaps some have been included which should have been omitted. I can only vouch for the fact that a goodly number of thoughtful colleagues have agreed that the list which follows includes books with which every qualified psychiatrist should be familiar. *How* familiar will depend to a considerable degree upon various factors. For example, some of these books are certainly not to be read cover to cover except by those having a special interest in particular topics, but their general content should be known to all.

I shall greatly appreciate comments, criticisms, additions and deletions from interested readers, and promise to attempt a revision of the list next year.

KARL MENNINGER, M.D.

Basic Readings in Psychiatry, 1948

NEUROLOGY

Grinker, Roy R.: *Neurology.* Springfield, Ill., Charles C. Thomas, 3rd edition, 1943.

or

Brain, W. Russell: *Diseases of the Nervous System.* New York, Oxford University Press, 1933.

or

Brock, Samuel: *Basis of Clinical Neurology.* Baltimore, Wm. & Wilkins, 2nd edition, 1945.

or

Spurling, R. Glen: *Practical Neurological Diagnosis.* Springfield, Ill., Charles C. Thomas, 3rd edition, 1944.

PSYCHOLOGY (Personology)

Hunt, G. McV. (editor): *Personality and the Behavior Disorders.* 2 volumes. New York, Roland Press, 1944.

or

Murphy, Gardner: *Personality.* New York, Harper & Bros., 1947.

and

Murray, H. A. *et al.: Explorations in Personality.* New York, Oxford University Press, 1938.

or

Allport, G. W.: *Personality: A Psychological Interpretation.* New York, Henry Holt & Co., 1937.

PSYCHOLOGICAL TESTING

Rapaport, David *et al.: Diagnostic Psychological Testing.* 2 volumes. Chicago, Yearbook Publishers, 1945 & 1946.

PSYCHOPATHOLOGY

Tomkins, Silvan S. (editor): *Contemporary Psychopathology.* Cambridge, Mass., Harvard University Press, 1943.

and

Maslow, A. H. and Mittelmann, B.: *Principles of Abnormal Psychology.* New York, Harper & Bros., 1941.

or

Menninger, Karl: *The Human Mind.* New York, Alfred A. Knopf, 3rd edition, 1945.

HISTORY OF PSYCHIATRY

Deutsch, Albert: *The Mentally Ill in America.* New York, Doubleday, Doran & Co., 1937.

and

Zilboorg, Gregory: *A History of Medical Psychology.* New York, W. W. Norton Co., 1941.

PSYCHIATRIC EXAMINATION

Appel, K. E. and Strecker, E. A.: *Practical Examination of Personality and Behavior Disorders in Adults and Children.* New York, The Macmillan Co., 1936.

or

Noyes, A. P.: *Modern Clinical Psychiatry.* Philadelphia, W. B. Saunders, 2nd revised edition, 1939.

PSYCHIATRIC SYNDROMES

Henderson, D. K. and Gillespie, R. D.: *A Textbook of Psychiatry.* New York, Oxford University Press, 1927.

or

Strecker, E. A.: *Fundamentals of Psychiatry.* Philadelphia, Lippincott, 3rd edition. 1945.

and

Kraepelin, Emil: *Dementia Praecox and Paraphrenia.* Edinburg, E. & S. Livingston, 1919.

or

Jung, C. G.: *The Psychology of Dementia Praecox.* New York, Nervous & Mental Disease Publishing Co., 1936.

or

Janet, Pierre: *The Major Symptoms of Hysteria.* New York, The Macmilan Co., 1907.

or

Jellinek, E. M.: *Alcohol Addiction and Chronic Alcoholism.* New Haven, Yale University Press, 1942.

PSYCHIATRIC ADMINISTRATION

Bryan, W. A.: *Administrative Psychiatry.* New York, W. W. Norton Co., 1936.

PSYCHOTHERAPY

Levine, Maurice: *Psychotherapy in Medical Practice.* New York, The Macmillan Co., 1942.

and

Wolberg, L. R.: *Hypnoanalysis.* New York, Grune and Stratton, 1945.

or

Brenman, M. and Gill, M.: *Hypnotherapy.* New York, International Universities Press, 1947.

MILITARY PSYCHIATRY

Grinker, Roy R. and Spiegel, J. P.: *War Neuroses.* Philadelphia, Blakiston, 1945.

or

Menninger, William C.: *Psychiatry in a Troubled World.* New York, The Macmillan Co., 1948.

CHILD PSYCHIATRY

Aldrich, C. A. and Aldrich, M. M.: *Babies are Human Beings.* New York, The Macmillan Co., 1938.

or

Freud, Anna: *Psychoanalysis for Teachers and Parents.* New York, Emerson Books, 1935.

or

Gesell, A. and Ilg, F. L.: *Infant and Child in the Culture of Today.* New York, Harper & Bros., 1943.

or

Allen, Frederick: *Psychotherapy with Children.* New York, W. W. Norton & Co., 1942.

and

Aichhorn, August: *Wayward Youth.* New York, Viking Press, 1935.

PSYCHIATRIC NURSING

Render, H. W.: *Nurse-patient Relationships in Psychiatry.* New York, McGraw-Hill Book Co., 1947.

and

Maine, Harold: *If A Man Be Mad.* New York, Doubleday & Co., 1947.

SOCIAL PATHOLOGY and CRIMINOLOGY

Elliott, M. A. and Merrill, F. E.: *Social Disorganization.* New York, Harper & Bros., 2nd edition, 1941.

and

Alexander, F. and Staub, Hugo: *The Criminal, the Judge, and the Public.* New York, The Macmillan Co., 1931.

PSYCHIATRIC SOCIAL WORK

French, L. M.: *Psychiatric Social Work.* New York, The Commonwealth Fund. 1940.

or

Towle, Charlotte: *Social Case Records from Psychiatric Clinics.* Chicago, University of Chicago Press, 1941.

INDUSTRIAL PSYCHIATRY

Roethlisberger, F. and Dickson, W. J.: *Managment and the Worker.* Cambridge, Harvard University Press, 1939.

or

Mayo, Elton: *The Human Problems of an Industrial Civilization.* New York, The Macmillan Co., 1933.

RELIGION AND PSYCHIATRY

James, William: *Varieties of Religious Experience.* New York, Longmans, Green & Co., 1938.

and

Freud, Sigmund: *Moses and Monotheism.* London, Hogarth Press, 1939.

or

Freud, Sigmund: *The Future of an Illusion.* New York, Horace Liveright, 1928.

ANTHROPOLOGY AND PSYCHIATRY

Freud, Sigmund: *Totem and Taboo.* New York, Dodd, Mead & Co., 1918.

and

Linton, Ralph: *The Study of Man.* New York, Appleton-Century Co., 1936.

or

Malinowski, B.: *The Sexual Life of Savages in Northwestern Melanesia.* 2 volumes. New York, Horace Liveright, 1929.

or

Kardiner, Abraham: *The Individual and His Society.* New York, Columbia University Press, 1939.

PSYCHOANALYTIC THEORY, ELEMENTARY

Freud, Sigmund: *A General Introduction to Psychoanalysis.* New York, Horace Liveright, 1920.

and

English, O. S. and Pearson, G. H. J.: *The Emotional Problems of Living.* New York, W. W. Norton & Co., 1945.

or

English, O. S. and Pearson, G. H. J.: *Common Neuroses of Children and Adults.* New York, W. W. Norton & Co., 1937.

or

Brill, A. A.: *Freud's Contribution to Psychiatry.* New York, W. W. Norton & Co., 1944.

PSYCHOANALYTIC THEORY, ADVANCED

Freud, Sigmund: *The Basic Writings of Sigmund Freud.* New York, Modern Library, 1938.

or

Freud, Sigmund: *The Problem of Anxiety.* New York, W. W. Norton & Co., 1936.

or

Hendricks, Ives: *Facts and Theories of Psychoanalysis.* New York, Alfred A. Knopf, 2nd edition, 1939.

and

Fenichel, Otto: *The Psychoanalytic Theory of Neuroses.* New York, W. W. Norton & Co., 1945.

PSYCHOANALYTIC THEORY, APPLIED

Alexander, Franz: *The Medical Value of Psychoanalysis.* New York, W. W. Norton & Co., 1932.

or

Menninger, Karl: *Man Against Himself.* New York, Harcourt, Brace & Co., 1938.

or

Deutsch, Helene: *Psychology of Women.* 2 volumes. New York, Grune & Stratton, 1944 & 1945.

PSYCHIATRIC MEDICINE ("Psychosomatic Medicine")

Cannon, W. B.: *The Wisdom of the Body.* New York, W. W. Norton & Co., 2nd edition, 1939.

and

Dunbar, H. F.: *Emotions and Bodily Changes.* New York, Columbia University Press, 2nd edition, 1938.

or

Weiss, E. and English, O. S.: *Psychosomatic Medicine.* Philadelphia, W. B. Saunders, 1943.

or

Binger, Carl: *The Doctor's Job.* New York, W. W. Norton & Co., 1945.

MENTAL HYGIENE MOVEMENT

Beers, Clifford: *A Mind that Found Itself.* New York, Doubleday, Doran & Co., 1936.

SUPPLEMENTARY LIST OF STRONGLY ENDORSED BOOKS

Angyal, Andras: *Foundations for a Science of Personality.* New York, The Commonwealth Fund, 1941.

Bond, Earl D.: *Dr. Kirkbride and His Mental Hospital.* Philadelphia, Lippincott, 1947.

Freud, Anna: *The Ego and the Mechanisms of Defense.* London, Hogarth Press, 1937.

Goldstein, Kurt: *The Organism.* New York, American Book Co., 1939.

Kinsey, Alfred C. *et al.*: *Sexual Behavior in the Human Male.* Philadelphia, W. B. Saunders, 1948.

Marshall, Helen: *Dorothea Dix.* Chapel Hill, University of North Carolina Press, 1937.

Mead, Margaret: *From the South Seas.* New York, Morrow, 1939. (This includes *Coming of Age in Samoa, Growing Up in New Guinea* and *Sex and Temperament in Three Societies.*)

Southard, E. E. and Jarrett, M.: *Kingdom of Evils.* New York, The Macmillan Co., 1922.

GENERAL LITERATURE

In the original draft of this list a number of books from classical literature were included such as the Bible, Goethe's *Faust*, Butler's *The Way of All Flesh*, Shakespeare's *Hamlet*, *Macbeth* and *King Lear*, Proust, Grimm, Aesop, Dostoyevsky, etc. After considerable thought it was felt that this list should either be considerably extended to include Sophocles, Voltaire, Rousseau and many others, or else that it should not be included here.

The reasons for this conclusion are complicated. Technical books are so few in number that it is much less difficult to make an acceptable selection than in the case of general literature where one has to consider both the classics and contemporary contributions of psychologically significant content. A list of the books making outstanding literary contributions to the understanding of psychopathology would not be the same list as one which undertook to establish a certain cultural background desirable for every psychiatrist. Certain transient books of no great literary value may possess outstanding psychiatric value, and certain classics of great literary value may not actually be indispensable, however desirable for the psychiatrist *qua* psychiatrist. It was concluded that the problem is sufficiently complicated and challenging to merit more study and the submission later of some tentative proposals.

This paragraph then will represent the implied inclusion of certain books from general literature to be more specifically listed later.

DYNAMIC ASPECTS OF THE TEACHING OF PSYCHOLOGY*

By RUDOLF EKSTEIN, Ph.D.

The subject of psychology offers an unusual challenge to the teacher and the group, for, unlike most other subjects, it deals with us as persons. We are its subject, and so the very tools we use to learn it are a part of it. It is true (and was true even before the day of psychosomatic medicine) that the medical student experiences psychological difficulties in learning subject matter which refers to his own self. One might add that subjects such as history, sociology, or economics are of a similar order. But it seems to me that psychology is even nearer to one's self, and concerns the self so much that particular situations will be encountered which can be used successfully in the teaching process.

The material of this paper stems from teaching experiences with college students and also from experiences in the adult education field and with popular lectures. It is perhaps the interesting differences in student bodies, in audiences, and also in the purpose of these assignments that created my particular interest in the dynamic aspects of the teaching process. A cursory examination of the motives of students in taking psychology courses will help the teacher to sense the psychological difficulties he must encounter in helping the students to acquire knowledge through the learning process. Usually the college student has to take psychology as a required course, and one of the main motivations the instructor can work with is the students' desire to meet the course requirements, that is, to pass the examinations. This motive is usually so strong in the majority of students that some instructors can impart psychological knowledge through prescribed reading in the required text book—at least so I have learned through hearsay. This kind of instructor does not have to watch any particular psychological reactions in the students or in himself. Nor does he have to use such observations to direct the learning process, because the powerful need for the student to pass the test enables the teacher to dole out the subject matter, psychology, without being aware of the psychological nature of the teaching process. But if he seeks psychological skill in teaching, he can give creative meaning to his particular function and can obviate the famous comment of George Bernard Shaw: "He who can does. He who cannot, teaches."

The questions of the students in class, or better, written anonymous comments from them, reveal a good number of their conscious as well as uncon-

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scious motives. Matriculated students can be helped to face and to overcome the psychological obstacle to creative learning when academic credit but not the merit of new knowledge motivates their attendance in class. The psychological discovery of an obstacle in learning may help a good many of them not only to overcome it but also to develop a genuine psychological interest.*

Such students will discover the psychological nature of their relationship to the teacher, and learn how this positive or negative, but usually ambivalent, transference situation influences the learning process. This discovery is a psychological one, and leads to insight and to understanding of a psychological relationship. Whenever the opportunity arises, the teacher will react to particular occurrences that stand in the way of the students' learning. He need not lecture on such subjects as *Transference* or *Fear of Examinations*, but he will try to sense the feelings of an individual or of the group and to use them for teaching purposes. Around examination time, for example, the teacher may sense that the students' anxiety or apprehension[10] about the test is revealing itself in a number of technical, intellectualized questions. He will interpret this not only to help remove this obstacle to efficient work during the test but also to help them use this emotional experience towards the acquisition of new psychological knowledge about people and similar social situations in everyday life.

The dynamic teacher of psychology will react to his students not only on an intellectual level but on an emotional level and thus free their intellectual powers for better learning. Once, during the discussion of psychological problems in reference to the concepts of heredity and environment, a student betrayed the intellectual and objective facade of his question by his apprehension. He wondered if insanity could be inherited. (This is a rather frequent question in psychology courses that may have a good many meanings behind it.) Instead of reacting to it intellectually and giving him only the factual answer, I mentioned first that a good many questions in class discussions may not stem originally from objective scientific curiosity, but are asked for emotional reasons such as anxiety about one's own mental health because of possible mental involvement of relatives. I then gave the requested information. The young man had the courage next time to tell me that one of his close relatives was actually ill, and that he discovered the emotional nature of his question himself though he was unaware of it at the time of asking. Another student started his

* Or the students may feel free of guilt and drop out of the course that does not meet their needs. It would be desirable if colleges could afford such freedom, as we know from experience that forced attendance and forced accumulation of knowledge will not lead to useful integration of psychological material into the students' personality.

question by saying that it was not a scientific but a personal one, and thus indicated his grasp of a very important and necessary discriminatory ability in the learning of psychological subject matter.

Psychology instructors today do not need proof that many students take psychology for personal reasons and tend to make the learning experience a substitute for mental hygiene or psychiatric treatment.† The danger of dynamic teaching therefore seems evident; that is, the students will consciously or unconsciously develop fantasies and all kinds of wishes about the teacher, will magnify his importance and "broaden" and change his function. They will want him to be not only a transmitter of knowledge, a helper toward the learning goal, but also to be their group or private therapist. It is for this reason that a good many well informed instructors, afraid of such situations, try to avoid any emotional involvement and hold on to tried and tested methods of presenting psychology as an intellectual system only. They prefer "to teach a subject rather than to teach students." There are others, however, who are so intrigued by the emotional needs of their students that they will proudly tell you that they try to do as much mental hygiene in class as possible. The latter are as unaware of the true function of psychology teaching as are the former of the psychological use of oneself in the teaching process. The teaching of psychology is not psychotherapy although there must and will be psychotherapeutic by-products in any educational activity that aims at a true evaluation of reality, particularly if it is psychological reality. The teacher's function in this respect is to interpret reactions, behavior, questions, failures, etc., in relation to the course objective and to his relationship with the students.

He should and must, however, equip himself with the necessary knowledge and skill for referral of students to proper mental hygiene and psychiatric resources within or outside the learning institution. Of course, if the teacher feels frustrated because he must teach psychology instead of doing therapy, he will have to find a solution for his own personality problem[5,7]. This indicates, I think, the need for teacher training that gives an emotional as well as an intellectual orientation. Psychoanalysis of teachers of psychology for didactic or therapeutic reasons is recommended[6], as well as professional supervision of their work, which should help them to be good teachers rather than would-be-therapists.

The desire to make use of psychological material in a practical manner is stronger, perhaps, in non-matriculated groups. If the teacher inquires as to the students' expectations in taking the course, almost every one will indicate a personal problem of an educational or therapeutic nature.

† Students are most likely as much in need of psychotherapeutic help as the general population of which we know that one out of twenty will require temporary or permanent hospitalization in a mental institution.

Learning, for this group, means acquiring new powers and abilities as well as knowledge and this attitude creates difficulties for the teacher as well as for them. Even more than in the academic setting the teacher must respond to the students' needs. He must maneuver between the dangers of Scylla and Charybdis, that is, he must avoid the pitfalls of text book chapter-by-chapter lecturing on the one hand, and the continuous temptations to conduct a kind of group therapy, on the other. Non-matriculated adult education groups are challenging not only because of their unusual, often naive, curiosity and their frequent intellectual limitations and lack of preparation for our courses, but also because they are not subject to the traditional academic system. In academic groups the teacher has authority not only because the student's desire to learn, to grow, to live up to their ego ideals but also because of the student's need to make a good grade and to satisfy the requirements of the college. This latter control, which finds expression in the tone of the psychological relationship between student and teacher, is totally missing in adult education groups. A substitute must be sought. I found it useful to make these students aware of this very fact. To help a group of students who do not work for credit to go through a course experience without substantial losses in members and without loss of interest can be achieved more easily, in my experience, when they are encouraged to work on the problem of their maturity in regard to learning.

I recall one group of students who found it very hard to end their experience with me. When we were discussing the psychological meaning of separation, I asked for their chief criticism. They complained that there were no assignments and tests as there "used to be in school." And while they were all grownups, it became clear to them during this final session that their disappointment in ending the course was the reactivation in them of an old childhood need to have a fatherly authority to reward and to punish them. They wanted more than the mature interest one may expect in a relationship among adults. Their awareness of their wish should lead to new insight into psychological principles through the meaningful experience in class.

It will be clear by now that whatever enters the teaching situation can be used in the learning process. Examples are: The formation of the learning group, the slow process of students' relating themselves to the leader-teacher, their individual and differing use of him, (whether it is toward learning or toward personal help, whether it expresses itself in rivalry or in competition for the best grade, whether it is in investing in him authority or non-existent intentions of a kind or evil nature) and the dynamic growth of the group through the learning process in this relationship. Other situations that can be turned to account are the students' selection of questions, their holding on to certain topics, their rejection of

others (or the teacher's pet subjects), and their choice of term paper topics and content. The awareness of all of these psychological aspects can be built into the knowledge that has to be acquired and will actually free students for more effective learning.

Learning is integration of new material, new skills into the ego. The relationship between the teacher and his class, however, constitutes an inter-play between all psychic forces, and true experience of growth can be achieved through its use. This is the powerful reason, even if usually unconscious, I am sure, for our holding on to a form of learning that seems to be outdated. The best textbooks, films, and radio facilities, the most modern technical and visual teaching aids, do not substitute for the main "tool" of learning—the relationship to the teacher.

Let me give another example: Once I had to substitute for a sick colleague who asked me to discuss the chapter on delinquency in his personality course. I entered a class of particularly unruly young people who, it was obvious, were reacting with "delinquency" to their teacher's absence. I decided to fall in with their wishes by giving them a kind of unexpected recess from learning. When they realized that the substitute teacher seemed to feel no particular responsibility to do his best for a class of "strangers" and might use the session as a little rest period for himself, they soon indicated, by settling down to a discussion of the lesson, that they were assuming the responsibility for a learning relationship by conferring on me the authority vested in their absent teacher. I was then able to point out that they had indicated a bit of delinquency in their own make-up and that they had subsequently demonstrated the importance of the student-teacher relationship as a tool for learning. Certainly they profited by the interpretation more than they would have by the display of mere sternness and authority.

It should be obvious by now that psychological aspects not only enter the teaching relationship but also affect the discussion of almost any subject. Good teaching will take account of them rather than take refuge in so called "systematic" teaching. It is my opinion that the psychological controls of psychology teaching ought to be used for graduate as well as undergraduate training, but I wish to add that a different degree of maturity and insight on the side of the students will change the level of the use we make of ourselves and of this relationship. It is also important to keep in mind the purpose of the course, because doing will need a different kind of instruction than mere knowing[4].‡

‡ A sample of "doing" instruction through personal supervision is given in the author's paper, "An Illustration of the Function of Supervision in the Learning Process"[4] where he tries to clarify how the personal relationship between teacher and supervisee affects, disturbs and aids the learning process towards interviewing skill.

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THE DIAGNOSIS AND TREATMENT OF SCHIZOPHRENIA*

By KARL MENNINGER, M.D.

When the chairman of the Interstate Post-graduate Medical Association invited me to speak to the members of this association "on the diagnosis and treatment of dementia praecox", I wrote in reply that I appreciated the invitation, but that this term "dementia praecox" had not been used by psychiatrists for twenty years. To this he responded somewhat in these words: "That is exactly why we want you to come and talk to us. There are a lot of old-fashioned fellows in this organization like myself who wouldn't know what you meant if you called dementia praecox anything else".

I will begin by explaining why I insisted upon the word "schizophrenia" instead of the word "dementia praecox" when the two words seem to some to mean the same thing. A good many doctors still think that it doesn't make much difference what you call any mental illness; to be mad, they agree with Shakespeare, is simply to be mad.

Fifty years ago there were many different kinds of "madness" in the books, and on the registers of the state hospitals. And consequently all psychiatrists welcomed the work of Emil Kraepelin of Germany who proposed to group together quite a few rather widely dissimilar conditions into one large category which he called "*dementia*" (because these conditions all seemed to have a malignant tendency and to tend toward deterioration) plus *praecox* (because this deterioration seemed to begin early in life.) While it was a great step forward for him to group all of these conditions together and to invent this term "dementia praecox", it was subsequently discovered that his inclusions had been rather too broad and his inferences as to the malignancy of the condition, its deteriorating tendency, and also as to its "precocious" appearance were somewhat unjustified. But by this time both the psychiatrists and the general public had become pessimistic about "dementia praecox" and it had become almost a foregone conclusion that a patient damned with the diagnosis of "dementia praecox" was hopeless. The doctors felt that way and acted that way, with the (partial) result that the patients often turned out to be that way. Kraepelin himself had specified that a very considerable proportion of these patients seemed to recover but the word "dementia" seemed to contradict that possibility.

Then a Swiss psychiatrist by the name of Bleuler pointed out that the fundamental similarity in these cases was not the tendency to "dement,"

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nor yet the tendency to begin early, but rather certain psychological peculiarities which could best be described as a kind of splitting of mental functions, a disturbance of the processes of association and of the normal connections of the emotions with ideas. He introduced the name *schizo-* (split) *phrenia* (mind). And with this new name and new concept, psychiatrists became more optimistic, and more efficacious.

It may be that changing the name of something does not change the condition, but it does change our attitude toward that condition. If I were to suggest that there might be as many as 10 cases of coronary sclerosis right here in this room among the doctors in my audience, I doubt if anyone would feel inclined to contradict me. It would not be any reflection upon anyone, and clinical experience would lead us to suspect that it might well be so. But if I were to say that there were probably 10 cases of *dementia praecox* right here in this room, I don't think you would like it and I don't think you would believe it. You would look around, furtively; you would see no one behaving in an unseemly fashion, and you would think that my guess was totally unjustified by the indications. But if I said that there might be 10 cases of *schizophrenia* right here in this room, I think you would be more inclined to think it over without protest; perhaps you would wonder what makes me think so, or upon what basis I draw such a conclusion. At any rate, you would not be so alarmed and you would not be offended. All because I changed a name.

You would probably want to ask me what the symptoms of incipient schizophrenia are so that, instead of looking about the room to see someone acting strangely, you would think of more careful tests, just as one would if he set out to see exactly how many cases of coronary sclerosis there might be in the room.

But before I plunge into the symptomatology of schizophrenia, I should like to talk rather more generally about the fact that doctors are so unfamiliar with this symptomatology of schizophrenia as compared to their familiarity with the symptoms of a much less prevalent disease, coronary sclerosis. It is generally agreed, I believe, that in the practice of medicine —outside of a few specialties—at least one-half of the cases which the average doctor sees in his office are cases of illness the like of which he never saw in medical school, the nature of which he was taught nothing about in medical school, and for the treatment of which he must depend upon his ingenuity, his common sense and his temperament rather than upon any scientific training that he has had. Some of these illnesses are unrecognized schizophrenia; some of them are hysteria; some of them are unnamable.

I think perhaps a third of medical practice consists of cases of organic pathology of the type shown in the scientific exhibits of our medical conventions. Another third of medical practice is made up of cases in which

there are a good many physical indications of illness, but indications connected so closely with the emotional life of the patient that while the doctor may begin by treating a part of the patient—his back or his head perhaps—he ends up by having the whole patient to treat, with all of his troubles, his marital difficulties, (and extra-marital difficulties, sometimes) his economic difficulties, and so on. Then there is another third of the cases constituting the practice of the average physician which is made up of patients who have to be called psychiatric; they are cases in which the symptoms are many and the signs are few, in which the patient suffers much but the family often more—and not infrequently the doctor, too. The patient has symptoms that distress the doctor partly because he (the doctor) doesn't know what to do and partly because whatever he does seems to be wrong. Or the doctor realizes that the proper consideration of the patient's symptoms take so much more time than he has available in his busy life that he enters into a half-hearted attempt to help the patient or even with a certain grudge against the patient, which defeats him before he starts. Hence, very often he gets rid of the patient as rapidly as possible in hopes that someone else will do the job.

The patients in this third category go by various names as I have suggested. Not all of them, by any means, can be said to suffer from neuroses although of course many of them do. Some of them are suffering from something more malignant. It is a very common error on the part of the general physician to think that any patient whose complaints seem to grossly outnumber his physical signs of illness is a neurotic. Many of them are not neurotic, but *psychotic.*

Now what is the difference between psychotic and neurotic? In every day language you know well enough what the difference is. A psychotic man, a patient with a psychosis, is one who is popularly described as "crazy". He is irrational, he is unpredictable, he is not entirely responsible, he is perhaps potentially or actually dangerous to himself or to the community. Such indeed is the picture of the full-fledged psychosis in most instances. But in the early stages, a psychosis does not take on these malignant features. It may appear very much more in the form that many physicians regard as a typical "neurosis", *i.e.*, a condition in which the patient complains a great deal about something for which there seems to be no organic cause.

Now, the commonest psychosis which masquerades as a neurosis (or sometimes as a mild physical ailment or even as a surgical condition) is schizophrenia. Schizophrenia is one very important, if not the most important, form of serious, malignant mental illness. By malignant I do not mean that it is incurable; a large proportion of cases of schizophrenia do not become seriously ill and a large number of them recover even after they

have become seriously ill. But there are so many cases of this illness in the country that it is still possible to say that a large number go through every doctor's office and are called by him cardiac disease, appendicitis, malingering and neurosis when they are actually early incipient schizophrenia. Some of them get better; some get worse. If they get worse, the schizophrenia becomes obvious. Most of the schizophrenia patients in every psychiatric hospital have been previously treated outside by doctors who thought they had a physical disease or a neurosis.

"What is this schizophrenia, then?" you may ask. "Surely it is something that I am missing for I do not see very many cases in my office that I would consider psychotic. You say it is so common, but I'll have to be convinced. If I have seen it so often, I am sure that I did not remotely suspect that I was seeing it."

You are quite right; I am sure that you did not suspect it. If you are called to a private home to see a young boy of 18 or perhaps a woman of twice that age; if the parents tell you that this beloved member of the family has not been himself; that he has been talking somewhat irrationally or inconsistently, and showing strange, pointless behavior out of keeping with his or her previous pattern, the chances are ten to one that you are observing an acute instance of schizophrenia and that you are well aware of it. Naturally you would exclude febrile delirium or hysteria (both of which are relatively rare) or intoxication (regrettably somewhat more common) and other conditions which it might be. Excluding these things you are almost certainly right that this is a case of schizophrenia. Inquiry from the family will probably supply the information that this strange behavior has been rather irregularly developing over a period of several weeks or months. The symptoms may have been of a quiet, silly dreamy type or they may consist of more or less hostile, suspicious, sullen and delusional behavior, or they may be a noisy, combative, disorderly type. We are all familiar with these three general pictures of disturbed (psychotic) behavior; what is common to them all is their irrational, illogical, unpredictable nature.

Such cases as this are easy to recognize, as I have said. Any good third year medical student would be able to recognize them if he had had any instruction in psychiatry at all. But such cases represent only one stage of schizophrenia, an acute or an advanced stage of the disease. It is a little like hemoptysis in tuberculosis. A sudden hemorrhage in a person who is not suspected of tuberculosis startles us, and we wonder why no one had detected it before; we know that the process has been developing over a period of time. Such a patient bleeds, he is rushed to a sanitarium, gets early treatment and has a better prognosis than the man who is suspected only of having a chronic cough or a bronchiectasis or something of

the kind and given no treatment until he is thoroughly under the domination of a tuberculous infection.

Now something of the same sort is true in schizophrenia. The phase of the illness I have described is easy to recognize and such a patient is apt to be rushed away to prompt treatment, and often prompt recovery. But I would say that the *slowly developing* cases are ten or twenty or maybe fifty times more common than those with the picture that I have just described.

Therefore, having given you this rather typical picture of the advanced or acutely flared case, let me get back to the earlier symptoms that one might have noticed in the same young man or woman had we seen him or her a year or two years or five years earlier.

First of all, we ought to say that it is more than likely that two or five years earlier one might not have noticed any symptoms at all in the patient. Indeed the relatives have already been quoted as having said that these symptoms were only of a few weeks or months duration. But the symptoms referred to were symptoms of the type shown by the patient when he was acutely ill. This does not mean that two years or five years or even ten years earlier there might not have been clues of what was going to happen. But the chances are that you would not have had an opportunity to notice these clues because the patient would not have been under medical scrutiny. But while he may not have been under medical scrutiny, he was certainly under someone's scrutiny—his teachers, his friends, his parents, etc. But these people were not looking for symptoms of illness. They were functioning with this individual in whatever roles they habitually fill. They were teaching him things, or giving him things, or playing ball with him, or whatever. He may have had his eccentricities and his peculiarities, but they were not regarded as illness.

But assuming that you could have looked in on this patient not as a teacher or as a parent, but as an observer and assuming that you might have been able to interview these teachers and parents, etc., what would you have found out about this child that would be a clue as to what was going to develop two or five years later in the form that we have already described?

You would have detected a certain interference with his contacts with other human beings, a kind of vague, slight, somewhat puzzling withdrawal. Beyond this you would have very likely detected nothing.

In the advanced stages of schizophrenia it is easy to see that the patient seems to have abandoned all loyalty to reality and the facts of life which we have all come by through the painful experiences of growing up. He acts as if he were in a dream, or was sleepwalking. In a dream the laws of gravity, time, space, color and identity, no longer hold, and so, also,

in the earlier stages of schizophrenia one can often detect this unrealistic, impractical, dream-like quality, by careful scrutiny. The trouble is that so many people have *spells* of this vagueness and withdrawal that it is a little difficult to say which person is developing what might be called a *malignant* dreaminess, a *malignant* impracticality and unrealistic attitude toward life. We all do a certain amount of daydreaming, self-deception, and scotomatizing of realities. But the normal person has a tendency to "come back", or "snap out of it", pitching into the activities of life again for what they actually are and not for what he wishes they were. The potential schizophrenic patient, however, has a tendency to go the other way as if he found the world of real life too painful to endure.

I am afraid I have made this appear much too clear and simple. A sensitive child grows up in what is for him a harsh world or a cruel world, and instead of committing suicide he merely relapses and regresses into a dream-like state, which becomes more and more obvious, and there you have it: *schizophrenia*. The only trouble is that that isn't the way it usually happens. Plenty of children grow up in what appears to be the best of environments and yet develop schizophrenia while plenty of others grow up amid hardships and sufferings a-plenty and come no where near having schizophrenia. Indeed some of the latter seem to be all the more realistic in their adjustments.

This has led many psychiatrists to believe that a special tendency to schizophrenia, some kind of hyper-sensitiveness at least, is transmitted by heredity. There is no proof of this, however. There is much proof that the injuries suffered by those individuals who later become schizophrenic occur very early in infancy. It may be the death of a mother, or neglect or harshness by the mother, incessant quarreling between the parents, hopeless rivalry with a much more popular or much more beautiful sister. Perhaps any, perhaps all of these things can do it. Some of them may occur even in the most gentle and kindly and affectionate of families. Something in the nature of an unendurable disappointment or wound causing unassuagable anger occurs in a child of special sensitiveness with inadequate devices for psychological adjustment; and over a period of years this malignant process of withdrawal develops—sometimes spontaneously arrested, sometimes suddenly manifest. Many events happen subsequently which reinforce the original injury, and it may well be that a certain unfortunate concatenation or repetition of such blows actually bring about the overt illness. The girl who is jilted by a lover at 21 and then develops schizophrenia may well have had a much more serious disappointment 18 years before that, and perhaps many others, but the final disappointment acts like the straw that broke the camel's back.

Children injured in this way are apt to develop certain defenses. They

cover up, as the slang expression puts it. They deny the injury which they have experienced or the pain which they are suffering. They erect a facade or front. "All's well with me", they seem to say. "I am one of the fellows; I am just like everybody else. I am a normal person." And indeed they act like normal persons, as much as they can. They go to the same schools, they complete the same work, they seek the same goals, they do the same things that all the rest of us do. Often they are noticeable only for a certain reticence, shyness, perhaps slight eccentricity. Just as often, they are not conspicuous at all. So much of this depends upon their ability or luck in maintaining this false front.

What is underneath that front? One might say that the same sort of thing goes on in the emotional life that goes on when an abscess slowly develops beneath the surface of the body, for example, in the lungs or in the liver. There has been an injury, an infection. Counteracting processes have been set up so that tenseness and pressure and potential pain are gathering. But all of this is concealed from the outsider. There is intense conflict and tension and anxiety and strong feelings of bitterness, resentment and hate toward those very people with which the external relationships may be so perfectly normal. "I hate them! They don't treat me right. They will never love me and I will never love them. I hate them and I could kill them all! But I must not let them know all this. I must cover it up, because they might read my thoughts and then they wouldn't like me and wouldn't be nice to me."

All this is covered up as long as possible—by trivial conversation, pleasant greetings, chat about the movies or the picnic and the next date, and the rest of the ordinary things of adolescent or early adult life. For the chief problem in the person who is going to develop what we call schizophrenia is, "How can I *control* the bitterness and hatred I feel because of the unendurable sorrow and disappointment that life has brought to me?" His efforts to control it often show themselves in various kinds of withdrawal, lone-wolfishness, seclusiveness, even mild suspiciousness, or just a quiet going of one's own way with disinterest in active social participation.

Thus it is really very difficult to detect schizophrenia in its early stages. Every psychiatrist sees a great many patients about whom he is undecided. Often he can not tell even after he has obtained a most complete life history, and the observations of many other people.

Fortunately we are not entirely helpless in the matter of diagnosis, however. Many of you will recall that before the Wassermann test for syphilis was introduced, a man was not recognized as having syphilis unless he had open lesions or some of the other well known clinical manifestations of syphilis. Sometimes we were not certain about the diagnosis from the observation of the lesions alone and particularly in these cases we were

very glad when the Wassermann test was discovered and proved to be of clinical usefulness. Then we found that many patients had syphilis who had no visible lesions at all!

In the same way there have been devised psychological tests which are useful to psychiatrists just as a Wassermann test is useful to internists. These tests not only help to make a definite diagnosis in doubtful cases, but they can be applied to apparently normal patients, and in such patients often reveal the presence of schizophrenic tendencies which do not show in any clinical way.

The average psychiatrist cannot do these tests. I cannot do them any more than I could do a Wassermann test, although I learned about the latter in medical school. But I do know what the results of a Wassermann test mean, and I do know what the results of such psychological tests mean, and I respect them equally. Using such tests, we know now that a great many cases that we used to call neuroses, neurasthenia, alcoholism, chronic invalidism, and many other things are actually cases of schizophrenia.

Hence, we have today a concept of schizophrenia very much broader than the one we used to have in the old "dementia praecox" days. We know now that there are actually many (potential) schizophrenics who do not become patients—who never become patients, neither yours nor mine. They often do very creditable and capable things in the world. Nevertheless, they are potential schizophrenics just as some of them may be potential coronary sclerotics and some of them potential diabetics. And as in the case of coronary sclerosis and diabetes, the regimen under which they live has much to do with their successful adaptation. Given certain new stresses, the facade may break down and the underlying bitterness and conflict may break through. The patient may suddenly begin to hear voices talking about him, saying that he is mean, that he is hateful. Or he may begin to detect the hostility of other people in a far larger measure than could possibly be true. He may begin to consider himself persecuted.

Or the break through may be like this: A little girl who was one of the most popular members of her community, president of her high school class and prominent in her Sunday school, calmly walked into her father's bedroom one night and shot him with a revolver. The following day she was the same "sweet, pleasant, demure but somewhat shy girl" that she had always been. No one could believe, at first, that she had really committed the murder. Nor could anyone believe, either, among those who knew and loved her, that she had schizophrenia. But the psychological tests showed it very clearly. One reads cases like this in the newspapers very frequently. What can anyone conclude about a girl who appears on the surface to be very sweet and lovable and yet who can calmly go in and kill her own inoffensive father "without batting an eye," so to speak, and

then return to her gentle demureness and appear to be as loving as ever? One can see how unrealistic, how contradictory, how perverse, how inconsistent, how really unrealistic such behavior is. But psychological tests are far more definite than these presumptions.

The most important cases of overt schizophrenia are not those in which the break through appears in such aggressive and violent direct action as I have described. In fact, most cases of schizophrenia are not dangerous. The commonest type of "break-through," the one that is most familiar to the doctors in this audience, is that in which the conflict appears in the form of *physical symptoms*. These physical symptoms usually appear as chronic pains in the abdomen or in the back or in the head. I could fill many pages with case histories of these. For example, a very successful saleswoman began to feel nervous and jittery when she was 44 years old. This was ascribed to the menopause. She began having recurrent attacks of pain in the back, feelings of anxiety and tremblings of the hands. She was given the usual medication for the menopause. This was of no particular benefit to her. She went from physician to physician; during the year in which she was examined by me she had seen 8 other physicians all of whom had assured her that there was nothing seriously or organically wrong. But a careful psychiatric examination confirmed by psychological tests showed that there was something very seriously wrong; she was developing an overt schizophrenia, and a year later she was in the locked wards of a psychiatric hospital.

The surgeon sees even more of these cases than the medical men, I suspect. And the surgeon is apt to be taken entirely unawares by them. I am not talking now about those cases which develop schizophrenic symptoms after an operation—which sometimes occurs. I am speaking of cases who come to surgeons with symptoms that suggest a so-called chronic appendicitis and other vague surgical affections. Sometimes the operation is very definitely indicated. Furthermore the curious phenomenon is often observed that an operation seems to postpone the outbreak of schizophrenia and sometimes to control it. I have seen many of these patients who have had operation after operation each time based upon physical symptoms, to be sure, but symptoms which developed in connection with the threatened outbreak of their schizophrenic tendencies.

I certainly don't mean by this that I think surgeons should operate merely for the purpose of forestalling schizophrenic attacks, because sometimes it has the opposite effect, as I have already mentioned. Furthermore, no surgeon wants to have his surgery turned into a placebo method. As yet we do not exactly know what to do with such patients, and it is a safe rule that the best thing to do is simply to follow the necessary established indications for imperative surgery.

A few words about treatment and prognosis, and I am through. When a case is definitely recognized to be one of schizophrenia, most physicians want to get rid of that patient. In this they are very wise. Of the many psychiatric conditions which physicians and surgeons who are not psychiatrically trained can and should handle, schizophrenia is not one. All psychiatrists believe and advocate that general physicians, internists and surgeons should treat many psychiatric patients. They have to, as a matter of fact. There are not enough psychiatrists to take care of one-fourth of the number of psychiatric patients now known to be seeking medical help and there will not be enough psychiatrists for many years. But in spite of this, I do not think that physicians and surgeons should attempt to treat schizophrenic patients. They are the most difficult, the most delicate, the most potentially disastrous of all psychiatric patients. By its very nature, as I have described it, which is that of repudiating reality and living in a self-limited, self-defined, self-created, self-ruled world, the schizophrenic patient puts himself outside of the jurisdiction of conventional medical practice.

I know that some physicians feel justified in administering electric-shock treatment to patients they consider to be schizophrenic as soon as they detect this. Psychiatrists in general and I in particular strongly condemn this procedure. In the first place electric shock is by no means the treatment of choice, if indeed it is of any use whatever, in schizophrenia. Insulin shock is sometimes beneficial, but it should be done only by someone with a great deal of experience in the selection of cases and in the administration of the treatment. Furthermore, it is generally agreed among psychiatrists that the effective use of any kind of shock therapy involves the strategic application and careful timing of psychotherapy, and to do this without preparation simply because one can apply an electrode or give a drug intravenously is dishonest and dangerous. Indeed, it is in my opinion, malpractice.

No, the treatment is not shocking the patient, but just the reverse. When it can be accomplished, the favoring of a natural reconstruction of the "facade" that I have described, the encouragement of a psychological healing process within the patient by the proper kind of environmental situation and the proper attitudes on the part of a therapist, and all the people about the patient—that is the treatment of choice. Schizophrenic patients often recover under the right treatment in the right environment, one in which it is not necessary for them to be afraid of their own fearful aggressiveness and resentment. Having been relieved of this fear they can gradually and firmly reconstruct the "front" with which to meet ordinary social contacts. Often, but by no means always, this treatment requires institutionalization; perhaps more often it requires the finding of an environment outside of an

institution (but often outside of the home) where the patient can successfully adjust himself. Above all, such patients should not be allowed to get into situations which they cannot stand, and if they are already in situations that they cannot stand they should be gotten into situations which require less of them. Whether a patient requires, in addition to such a change in his life situation, the special psychotherapeutic treatment which a psychiatrist can give would depend upon the individual case and upon the severity of the symptoms. The vast majority of schizophrenics at the present get no treatment, but many of them would be very much helped by some protective, supportive treatment which their family physician could give them and a great many could undoubtedly be improved, if not cured, by the proper type of special psychiatric treatment.

The prognosis of schizophrenia is much better than most people think. If one is going to judge it by the terrible cases (and they are too many and too terrible) that never get well, cases which fill the state hospitals, then one has a right to be pessimistic. But one should remember two things. In the first place many of these patients remain ill just because they are pessimistically regarded, and hence neglected. In the second place even these thousands of hopeless patients constitute *a small minority* of the total of cases of schizophrenia. I am not speaking now of the latent cases of schizophrenia, but even of the overt cases. If a medical student was shown only the advanced, ulcerative, disseminated stage of carcinoma he would certainly come to the conclusion that it is a rare and an incurable disease. And yet we all know that early cases of carcinoma can be successfully treated and are being successfully treated. *Schizophrenia has a much better prognosis than carcinoma*, and on the same basis, namely, that it be recognized early for what it is and not taken to be something else—appendicitis, idiopathic pruritis vulvae, or neurasthenia.

BOOK NOTICES

New Fields in Psychiatry. By DAVID M. LEVY. Price $2.75. Pp. 171. New York, W. W. Norton & Company, Inc., 1947.

This is a 170 page book reporting the Salmon Lectures in 1947 as given by Doctor Levy. It is divided into eleven chapters that briefly set forth some of Doctor Levy's point of view and expe iences in child guidance, comparative psychiatry, delinquency, social work, educational psychiatry, industrial psychiatry, military psychiatry, induction centers, personnel selection and political psychiatry. The book represents a progressive and suggestive set of ideas that are interesting and easy reading.

The book is concluded with a forty page, sample case study of some of his work in the selection of anti-nazi publishers among the populace in Germany under the U. S. government auspices immediately following the war. (W.C.M.).

Suggestive Therapeutics. By H. BERNHEIM. Price $5.00. Pp. 420. New York, London Book Co., 1947.

Another reflection of revived interest in hypnosis as an aid in psychotherapy is the reprinting of this work, the historical importance of which lies in its articulate expression of the passionate battle between the "physicalists" of Charcot's Paris school and the "suggestionists" of the Nancy school. It is in the work of the latter group that modern concepts of hypnosis as a psychological phenomenon are rooted. In Bernheim's time "suggestion" was used broadly to represent psychological theories of hypnosis as opposed to those of the "physicalist" school. As the intensity of this debate has lessened with the development of psychodynamic theories of personality and hypnosis, "suggestion" as an explanation of hypnosis has completely lost its value.

From the wealth of clinical material, the author concludes: (1) hypnosis is not a pathological state analogous to hysteria but a phenomenon closely allied to sleep; (2) a "real willingness" to be hypnotized is requisite for success; (3) children are in general more amenable than adults; (4) in melancholia, hypochondriasis and "certain neuropathic cases" resistance to hypnosis is very great.

Although this book may seem primitive in its lack of psychodynamic understanding, it remains one of the most reliable sources of observation of the phenomena of hypnosis and a milestone in the history of treatment by psychological techniques. (Margaret Brenman, Ph.D.).

The Nurse-Patient Relationships in Psychiatry. By HELENA WILLIS RENDER. Price $3.00. Pp. 346. New York, McGraw-Hill Book Company, 1947.

An intelligently and simply written textbook, clarifying the problem of nurse-patient relationships and suggesting methods of treatment. An excellent explanation of Attitude Therapy is given with specific examples of what to do with certain types of behavior reactions. Recommended for general as well as psychiatric nursing libraries. (M. Olga Weiss R.N.).

Problems of Early Infancy. Edited by MILTON J. E. SENN. Price $.75 Pp. 70. New York, Josiah Macy, Jr. Foundation, 1947.

This 70 page booklet contains a report on the first of a series of conferences called together by the Josiah Macy, Jr. Foundation for a discussion of the problems of early infancy. The conference was attended by 22 members, representing a cross section of the professional disciplines concerned with infant welfare. The report contains 14 separate brief papers, dealing principally with new devices in infant care such as rooming-in and self-demand schedules.

Seven chapters report on practical experience with these devices in various localities and from various points of view. The remaining papers present more theoretical discussion of the issues involved, most presenters being either psychoanalysts or analytically oriented. The overwhelming majority of discussants expressed almost unqualified approval of rooming-in and self-demand procedures; only 2 stressed the need for more systematic investigation and felt that these methods can be used to good advantage only with well adjusted mothers.

For those interested in concrete aspects of infant care the booklet provides reliable information on up to date methods. Since the purpose of this conference is the exchange of opinions among various professional disciplines this report does not give a comprehensive view of the problems of early infancy but rather an informal discussion of various aspects. (Sibylle Escalona, Ph.D.).

Some Special Problems of Children Aged Two to Five. By NINA RIDENOUR in collaboration with ISABEL JOHNSON. Drawings by Barbara Cooney. Price $.75 per set. New York, New York City Committee on Mental Hygiene, 1947.

An appealingly designed as well as interestingly and reassuringly written series of pamphlets is now available to parents, both new and not so new. They have been prepared so as to satisfy, as well as any written and generally applicable material can, the parent's curiosity about "Why does he do it?" and "What shall I do about it?" (with the authors implying when not stating what should I *not* do about it). The series includes: 1. When a Child is Destructive. 2. When a Child Masturbates. 3. When a Child Still Wets. 4. When a Child Hurts other Children. 5. When a Child has Fears. 6. When a Child Won't Share. 7. When a Child Uses Bad Language. 8. When a Child Still Sucks His Thumb. (Catharine Menninger).

Doctors Differ: Five Studies in Contrast By HARLEY WILLIAMS. Price $3.50. Pp. 253. London, Jonathan Cape, 1946.

Five medical biographies written by a London psychiatrist whose visit to us some ten years ago is pleasantly remembered. Of these, the most interesting to psychiatrists will be that of John Elliotson, an early 19th century physician who caught a vision of the importance of hypnosis, but in spite of a valiant fight against orthodox medical opinion was defeated and discredited. Thereby, as the author says, the new science of psychiatry was condemned to die a premature infant. For over fifty years after

Elliotson, mental illness and mental hospitals were left out of medical consideration.

In addition, the lives of Hugh Owen Thomas, eccentric bone-setter of Liverpool and uncle of the famous Sir Robert James who founded orthopedics, the cardiologist James McKenzie, the internist Wm. Osler, the neurosurgeons Wm. Macewen and Victor Horsley, and the phthisiologist Sir Robert Phillip are sketched. (Karl A. Menninger, M.D.).

Spiritism. By G. H. Estabrooks. Price $3.00. Pp. 235. New York, E. P. Dutton & Co., 1947.

This is an examination of some of the data regarding alleged telepathy mediums, spirit communication, etc. Like William James, the author, who is a competent psychologist and educator, is able to give an explanation for some of these phenomena, to guess at explanations for some others and to conclude regarding still others that we have no valid explanations. He does not go as far as Rhine or Eisenbud, but he does go a little further than Freud. (K. A. M.).

Thematic Apperception Test. By Silvan L. Tomkins. Price $5.00. Pp. 297. New York, Grune & Stratton, 1947.

Dr. Tomkins has done more in this volume than ably describe the test and review conscientiously 15 years of T.A.T. literature. Being one of the main contributors in research on projective techniques he has, for example, introduced a new scoring system and has deepened the meaning of the psychoanalytic concept of repression in order to adapt it to T.A.T. level analysis.

His book can be looked at as a projection, a "story" response of the psychological profession, and thus shows the many different uses of the T.A.T. structure in different branches of psychological and sociological inquiry and application, in the framework of different psychological ideologies.

A comparatively small part of the volume concerns itself with the use of the T.A.T. in therapy which again is perhaps a reflection of the present situation in clinical psychology.

Dr. Tomkins' own efforts seem to indicate a shift in emphasis, a more useful occupation with diagnosis for therapy, with aspects of the psychotherapeutic relationship, and the problem of therapeutic change. This volume is highly recommended as a basic text and as an asset to the expert. (Rudolf Ekstein, Ph.D.).

Epilepsy. Psychiatric Aspects of Convulsive Disorders. Edited by Paul H. Hoch and Robert P. Knight. Price $4.00. Pp. 214. New York, Grune & Stratton, 1947.

A collection of fifteen papers, this book presents many data from psychological, sociological, clinical and laboratory workers. Numerous approaches other than psychiatric are included, despite the title; and the quality of the papers ranges from good to extremely poor in content and presentation. One feels that convulsive disorders are seen quite differently by writers in different fields. But certain generalities seem well established;

that epilepsy is a number of diseases with common symptoms—episodic, repetitive changes in consciousness; that a threshold for such changes and for convulsions exists in the nervous system of higher animals; that unknown processes may lower this threshold; that precipitating factors for an attack may be brain-traumatic, chemical or affective, endogenous or external; and that treatment remains largely empirical, however much the ideal of personality-as-a-whole is advocated. The difficulty appears to be that of dealing holistically with any problem so long as its essential nature stays unformulated. (R. L. Sutherland, M.D.).

Child Development and the Curriculum. By ARTHUR T. JERSILD in collaboration with MARY E. CHAYER, CHARLOTTE FEHLMAN, GERTRUDE HILDRETH, AND MARION YOUNG. Price $2.75. Pp. 274. New York, Bureau of Publications, Teachers College, Columbia University, 1946.

The experiment in child development conducted by The Horace Mann-Lincoln Institute of Teachers College, Columbia University, is reported in this book. The authors review the child's development from birth through adolescence. The child's ability and capacity at each age level is indicated. The numerous research projects in progressive education are critically presented. This book is highly recommended for educators, superintendents, and guidance directors. (E. D. Greenwood, M.D.).

Treatment Considerations in the Reassignment of Clients. By REGINA FLESCH. Price $0.85. Pp. 81. New York, Family Service Association of America, 1947.

While written primarily for the social work practitioner in a family welfare agency, the problems presented (those involved in transferring a worker (therapist) to another) are also basic to other helping relationships.

Through a generous use of case illustrations the author presents a study of the dynamics involved for the client (patient) as well as the worker faced with a separation experience. The second portion of the monograph deals with the technical skills involved in enabling the client to make the transition.

Such questions as should the case be terminated or transferred; how can the worker's impending departure be used dynamically to facilitate progress in treatment; what goes into selecting a new worker, are also considered. The treatment of this problem as one worthy of serious professional consideration should prove interesting not only to social workers but to psychiatrists as well. (Marcia A. Leader).

Introduction to Methods in Experimental Psychology. By MILES A. TINKER. Price $4.00. Pp. 232. New York, D. Appleton-Century Company, 1947.

In the preface, Epictetus is quoted as saying, "Sheep are not to produce the grass which they have eaten, but wool and milk." This is an apothegm which every teacher might thoughtfully contemplate. The book itself is designed to provide beginning psychology students with experience in performing simple "experiments" and in describing the procedure, results,

and conclusions in acceptable ways. The "experiments" range from an investigation of "color preferences" to the "measurement of introversion-extroversion." The author is to be commended for minimizing the quantity of dull and meaningless "exercises" usually encountered in books of this type and for the remarkably clear descriptions of basic statistical methods. (Robert C. Challman, Ph.D.).

Unhappy Marriage and Divorce. By EDMUND BERGLER. Price $2.50. Pp. 167. New York, International University Press, 1946.

Dr. Bergler's special interest in problems of human adjustment that affect marital relationships has yielded many fruitful contributions in psychoanalytic literature. This new book is no exception. It contains excellent discussions of unconscious factors in the life of neurotic people that lead to unhappiness in marriage and to divorce. Particularly well formulated seems his explanation of love in its tender and sexual aspects.

Since he sees these problems from the point of view of the psychoanalyst whose method of alleviation is analytic treatment he rejects any explanation of a sociological or even ego-psychological nature. Formulations that aim at unconscious motivations will be appreciated and understood by the analytically oriented clinician.

But for the lay person and for the scientist from other fields some of his conclusions will give the impression of dogmatism. Since it seems that the author wrote the volume for the reading public it is felt that he may arouse resistance rather than new conviction. While one may then take issue with the provocative manner of his presentation one certainly will want to recommend the book to those who are identified with psychoanalysis and therefore will realize that his "explanations" refer to psychoanalytic treatment and not to many other psychological and sociological aspects of marriage. (Rudolf Ekstein, Ph.D.).

Chronic Disease and Psychological Invalidism; A Psychosomatic Study. By JURGEN RUESCH in collaboration with ROBERT E. HARRIS ET AL. Price $3.00. Pp. 191. New York, The American Society for Research in Psychosomatic Problems, Inc., 1946.

Chronic Disease and Psychological Invalidism is a very serious 150 page study of a neglected problem in psychosomatic medicine, dealing with patients selected on the basis of chronicity and incurability, with the implicit expectation (which is made fairly explicit in the introduction) that this incurability is sometimes itself a symptom, and a symptom of an unseen, unrecognized factor in the illness. The authors very carefully study approximately 200 patients in quite a number of different ways. There are some social statistics, educational statistics, occupational statistics, marriage statistics, Minnesota multiphasic personality inventory profile statistics, and many others relating to categorical data obtained from the patients. There is a discussion with excellent illustrations of certain situational conflicts, certain character problems, certain social and cultural obstructions to recovery. There is a short and very practical section on treatment (perhaps the best section in the book). (K. A. M.).

Psychoanalysis and the Social Sciences, Vol. I. Edited by GEZA ROHEIM. Price $7.50. Pp. 427. New York, International Universities Press, 1947.

Fifteen articles are contained in this new annual. Roheim, the editor, contributes a discussion of the relation of psychoanalysis to anthropology and an exposition of dream analysis as it may be used in anthropological field work. Spitzer writes of Japanese character structure, and there is an excellent article by Kluckhorn on Navaho child-rearing practices. The relation of the Narcissus myth to the idea of death is explored by Bunker. Several papers offer psychoanalytic interpretations of social phenomena—rituals and games (Bunker, Feldman, Lorand); Negro race prejudice and race riots, which Sterba links with sibling rivalry and father hatred, respectively; and religious experience (Hitschmann). It is clear from many of these papers that despite sociologists' objections, the myth of the "primal horde" is accepted as unreservedly as ever. Creative writing is examined by Oberndorf and by Bergler, the latter characteristically stressing its oral determinants. Kris and Leites compare democratic with totalitarian propaganda, and discuss differences in propaganda during World Wars I and II. A very thorough and thoughtful historical paper on anti-semitism by Loewenstein is included. In terms both of psychoanalysis and social science, however, the most basic of all these contributions unquestionably is Hartmann's analysis of rational and irrational action. (Louisa P. Holt, M.A.).